BEAVER COUNTY
EMPLOYEE'S REPORT FOR WORKER'S COMPENSATION

Employee's name:_____ Phone:_____

Address: _____
(No. and Street) (City or Town) (State) (Zip)
Social Security#: _____-___-_____ Date of Birth: _____/_____/_____

Male ___ Female ___ Married ___ Single ___ Number of dependent children: _____

Date of Hire: ___/___/_____ Department: _____

Job Title: _____ Normal work hours _____ per week

Exact location of injury or accident: _____

Was place of accident or exposure on employer's premises? _____

Date of injury or accident: _____/_____/_____ Time of injury or accident: _____

What shift: _____ Property or equipment involved: _____
(If applicable)
What task was employee doing when injured? _____

Description of incident and injury to person involved (be specific): _____

_____

Body part(s) involved: _____

Names of witnesses: _____

Attending physician: _____Time missed: _____

Have you returned to work? Yes ___ No ___ If so, when?: ____/____/_____

Comments: _____

Supervisor's initials acknowledge employee's report of accident: _____ Date: _____

Employee's Signature and Date: _____

Date of report: _____/_____/_____

*** Form must be completed *in full* in order for claim to be processed.**

BEAVER COUNTY
SUPERVISOR'S REPORT OF EMPLOYEE INJURY OR ACCIDENT

EMPLOYEE'S NAME_____ DEPARTMENT_____

LOCATION OF INCIDENT_____

DATE OF INCIDENT_____ TIME_____ DATE REPORTED_____

WHAT SHIFT WAS EMPLOYEE WORKING? _____

TO WHOM WAS INCIDENT REPORTED? _____

DESCRIPTION OF INJURY (BE SPECIFIC) _____

_____

PART(S) OF BODY INJURED_____

NAME OF WITNESS_____

WAS THERE EQUIPMENT INVOLVED? IF SO, EXPLAIN_____

_____

WAS ACCIDENT CAUSED BY AN UNSAFE ACT? IF SO,
EXPLAIN_____

WAS ACCIDENT CAUSED BY AN UNSAFE CONDITION? IF SO, EXPLAIN_____

_____

WHAT COULD MANAGEMENT HAVE DONE TO PREVENT THE INCIDENT? _____

_____

WHAT COULD EMPLOYEE HAVE DONE TO PREVENT THE INCIDENT? _____

_____

DOES INJURY CONCUR WITH EMPLOYEE'S REPORT? _____

WAS MEDICAL OR EMERGENCY TREATMENT NECESSARY? YES _____ NO _____

TYPE OF MEDICAL TREATMENT PROVIDED (DOCTOR, FIRST AID, AMBULANCE TO HOSPITAL _____

_____

ATTENDING PHYSICIAN (NAME AND ADDRESS) _____

_____

LOST TIME FROM WORK (ESTIMATED) _____DAYS _____HOURS _____NONE

ANY ADDITIONAL INFORMATION _____

*PREPARED BY _____ TITLE_____

*SUPERVISOR'S SIGNATURE IS VERIFICATION THAT THE VALIDITY AND COMPLETENESS OF THE ABOVE STATEMENTS HAVE BEEN CHECKED.

DATE _____

Notice to Employees
Workers' Compensation Physician Panel

The County of Beaver County

Zurich
P.O. Box 1880
Pittsburgh, PA 15230-1880
1-800-888-8765

If you sustain an injury while at work, you must notify your supervisor immediately, who will assist in reporting your claim to your workers' compensation insurance carrier. The following conditions apply to your work related injury or illness:

1. You must seek care from one of the Panel Physicians listed below for your initial treatment and for the next ninety (90) days of treatment. Failure to comply with this requirement may result in denial of payment.
2. Your Employer is responsible for medical treatment, medicine, equipment supplies that are reasonable and necessary for your work related injury.
3. You have the right, during the first 90-day period, to switch from one healthcare provider on the attached list to another.
4. Your employer will be responsible for any treatment received from a provider you have been referred to b your designated provider.
5. You may seek emergency medical treatment from any provider, but all subsequent non-emergency treatment shall be received by a designated provider for the remainder of the 90-day period.
6. Your employer shall pay for reasonable, necessary and causally related medical treatment received from any healthcare provider after the 90-day period has ended, as long as you notify your employer of the action or choice within 5 days of the visit to your provider of choice.

Physician	Address	Phone	Specialty
Med Express	3944 Brodhead Rd., Suite 7B Monaca, PA 15061 Wal-Mart Plaza	(724) 773-0777	Insta-Care
Beaver Valley Eye Center	95 A Golfview Drive Monaca, PA 15061	(724) 770-9000	Ophthalmology
Association of Specialty Physicians	1030 Beaner Hollow Road Beaver, PA 15009	(724) 775-4242	Orthopedics
Center for Rehab Services	1200 Sharon Road Beaver, PA 15009	(724) 728-4545	Physical Therapy
Center for Rehab Services	3627 Brodhead Road Monaca, PA 15061	(724) 728-7676	Physical Therapy
Center for Rehab Services	1415 Sixth Avenue Beaver Falls, PA 15010	(724) 843-7930	Physical Therapy
Center for Rehab Services	151 Professional Building 99 Buss Road Aliquippa, PA 15001	(724) 375-8323	Physical Therapy
Associated Occupational Therapists, Inc.	1630 State Street West Baden, PA 15005	(800) 225-9675	Physical Therapy
John Gump, DC PC	1012 8th Avenue Beaver Falls, PA 15010	(724) 846-7489	Chiropractic

IN CASE OF MEDICAL EMERGENCY
Seek care at the closest hospital Emergency Room. In such situation, you or a designated person must contact your Supervisor or Workers' Compensation Office as soon as possible.

ZURICH
Zurich U.S.Insurance
P.O. Box 968053
Schaumburg, IL 60196-8053
1-800-888-8765

Pharmacy Program

The Zurich Pharmacy Program is covered through Cypress Care. Please be sure to give the pharmacy the following information:

Process Prescriptions through Cypress Care:

BIN # 010876
Group # CC1019
Member ID: Your Zurich claim number

To check for other participating pharmacies or for any questions regarding Cypress Care, please contact them at **1-800-419-7102.**

Local Pharmacies:

Giant Eagle Pharmacies
Rite Aid Pharmacies
CVS Pharmacies
Eckerd Drug
Brighton Pharmacy
WalMart Pharmacies
Target Pharmacies

ZURICH
Zurich U.S.Insurance
P.O. Box 968053
Schaumburg, IL 60196-8053
1-800-888-8765

REMINDER TO EMPLOYEE

If this claim is not compensable under the Worker's Compensation Act, any medical bills incurred will be the responsibility of the employee, and you should file these bills under your regular health insurance, if applicable.

_____

Your signature / Date

RIGHTS AND DUTIES

Your signature on this panel indicates that you have been informed of and you understand these rights and duties. If you have questions, be sure you have your rights and duties explained to you before signing this form.

I HAVE BEEN INFORMED OF MY MEDICAL TREATMENT RIGHTS AND DUTIES WITH REGARD TO WORK-RELATED INJURIES AND OCCUPATIONAL ILLNESSES.

Employee Signature: _____ Date: _____

Employer Representative: _____ Date: _____